### REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE [Take or mail original and all copies to your local Social Security Office] ON REVERSE SIDE OF FORM.

## PRIVACY ACT NOTICE

1. CLAIMANT	2. WAGE EARNER, IF D	DIFFERENT	3. SOC. SEC. CLAIM NUMBER	4. SPOUSE's CLAIM NUMBER			
5. I REQUEST A HEARIN	IG BEFORE AN ADMINISTRATIVE LAW JUDG	GE. I disagree w	l vith the determination made on my	claim because:			
You will receive notice of	Judge of the Office of Hearings and Appeals of the time and place of a hearing at least 20	days before th	e date set for a hearing.	er proceedings in your case.			
block and complete the	evidence to submit check the following ne statement:	7. Check one of the blocks:					
l have additional evid (Name and address o		I do not wish to appear and I request that a decision be made based on the evidence in my case.  (Complete Waiver Form HA-4608)					
Attach an additional s	ne Social Security Office within 10 days. sheet if you need more space.)						
	represented at the hearing. If you are not reprice organizations. (If you are represented, co			ity Office will give you a list			
available to complete th	No. 8 and your representative (if any) shows is form, you should also print his or her name	e, address, etc.		your representative is not			
8. (CLAIMANT'S SIGNATU	RE)	9. (REPRESENTATIVE'S SIGNATURE/NAME)					
ADDRESS		(ADDRESS) ATTORNEY; NON ATTORNEY					
		(ABBIIEGG)					
CITY	STATE ZIP CODE	CITY	STATE	ZIP CODE			
DATE	AREA CODE AND TELEPHONE NUMBER	DATE	AREA CODE	AND TELEPHONE NUMBER			
TO BE COMPLETE	D BY SOCIAL SECURITY ADMINIST	L ΓRATION-Α	CKNOWLEDGMENT OF REC	DUEST FOR HEARING			
10. Request for Hearing REC	CEIVED for the Social Security Administration	on	by:				
(TITLE)	ADDRESS		Servicing	g FO Code PC Code			
11. Is the request for h reconsidered determ YES NO	earing received within 65 days of the nination?		ed, attach claimant's explanation fontice, letter, or other pertinent m				
12. Claimant not represe		13. Interprete	r needed -				
14.	and service organizations provided	15.	guage (including sign language):				
Check one: Initial Er	ntitlement Case y Cessation Case	Check claim t	ype(s):	/ <b></b> )			
Other Po	ostentitlement Case	l <b>=</b>		(DIMC)			
16. HO COPY SENT TO:	HO on		-Widow(er) only	(DIWW)			
	itle II; Title XVI; or		only				
Title    CF held in FO  CF requested: T	to establish CAPS ORBIT; or itle II; Title XVI		only	(CCID)			
	phone report attached).	<b>=</b> '	/Title II	(CC A C)			
17.		SSI Blind,	/Title	(SSBC)			
CF COPY SENT TO:		l <del></del>	pility/Title II	/I II = \			
CF attached: T	itle II; Title XVI	HI Entitle Other-Sp	ment	· · · · · · · · · · · · · · · · · · ·			
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5. I REQUEST A HEAR	ING BEFORE AN ADMINIS	TRATIVE LAW JUDG	<b>GE</b> . I disagre	e with the de	termination made on my	r claim because:	
	v Judge of the Office of I e of the time and place of					er proceedings in your cas	
6. If you have addition block and complete	nal evidence to submit che	ck the following	7. Check one of the blocks:				
·	idence to submit from		wish to appear at a hearing.				
(Name and address		do not wish to appear and I request that a decision be made based on the evidence in my case.  (Complete Waiver Form HA-4608)					
	the Social Security Office I sheet if you need more s						
	e represented at the heari rvice organizations. (If yo					ity Office will give you a li	
	No. 8 and your represent No this form, you should also					l your representative is n	
8.	ans form, you should also	printernis of nor nume	9.	, , , , , , , , , , , , , , , , , , ,			
(CLAIMANT'S SIGNAT	TURE)		(REPRESENTATIVE'S SIGNATURE/NAME)				
ADDRESS			(ADDRESS) ATTORNEY; NON ATTORNEY				
CITY	STATE	ZIP CODE	CITY		STATE	ZIP CODE	
DATE	AREA CODE AND T	ELEPHONE NUMBER	DATE		AREA CODE	AND TELEPHONE NUMBER	
TO BE COMPLET	ED BY SOCIAL SEC	URITY ADMINIS	 	ACKNOW	LEDGMENT OF REC	QUEST FOR HEARING	
10.	ECEIVED for the Social Se				by:		
<b>-</b>		<b>,</b>					
(TITLE)		ADDRESS				g FO Code PC Code	
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12. Claimant not repre				eter needed			
14.	l and service organization	s provided	15.	anguage (Incl	uding sign language):		
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	Title II; Title XVI; o					(CCID)	
CF requested:	O to establish CAPS ORBI Title II; Title XVI	I; or	I —			(CCID)	
	r phone report attached).					/CC A C	
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=	Title II; Title XVI		==				
Other attached	Other attached			-Specify: (			

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		of Hearings and Appeals of a hearing at least 20				er proceedings in your case.		
	onal evidence to submit te the statement:	check the following		7. Check or	ne of the blocks:			
·	vidence to submit from		wish to appear at a hearing.					
(Name and addres				I do not wish to appear and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)				
Attach an addition	o the Social Security Of al sheet if you need mor	e space.)						
		earing. If you are not rep you are represented, co				ity Office will give you a list		
available to complete		resentative (if any) shou Iso print his or her name	, address,			d your representative is not		
8. (CLAIMANT'S SIGNA	TURE)		9. (REPRESENTATIVE'S SIGNATURE/NAME)					
ADDRESS			(ADDRESS) ATTORNEY; NON ATTORNEY					
CITY	STATE	ZIP CODE	CITY		STATE	ZIP CODE		
DATE	AREA CODE ANI	O TELEPHONE NUMBER	DATE		AREA CODE	AND TELEPHONE NUMBER		
TO BE COMPLE	TED BY SOCIAL SI	CURITY ADMINIST	I TRATION	-ACKNOW	LEDGMENT OF REC	QUEST FOR HEARING		
10. Request for Hearing I	RECEIVED for the Social	Security Administration	on		by:			
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reconsidered de	_	1 00 days of the	appointme		•	aterial or information in the		
12. Claimant not rep	resented - ral and service organizat	ions provided		eter needed	- luding sign language):			
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Title    CF held in	FO to establish CAPS O	, RBIT; or	_			(CCID)		
CF requested:			1 ==			(CC A C)		
	or phone report attache	A) i	. =	•		(CCBC)		
17. CF COPY SENT T	O:	HO on		·				
CF attached:	Title II; Title XVI		==	· ·		/LUE\		
Other attached			Other	-Specify: (		)		

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	w Judge of the Office of Hearings e of the time and place of a hearin					her proceedings in	your case.	
	nal evidence to submit check the t e the statement:	ollowing	7. Check one of the blocks:					
have additional ev	vidence to submit from							
(Number and address)	5 01 30d100).		(Complete Waiver Form HA-4608)					
Attach an addition	o the Social Security Office within al sheet if you need more space.)	,						
	pe represented at the hearing. If you ervice organizations. (If you are re				to be, your Social Sec	ırity Office will giv	e you a list	
	te No. 8 and your representative this form, you should also print hi				ou are represented a	nd your representa	ative is not	
8.	.,, .	9						
(CLAIMANT'S SIGNA	TURE)	( F	REPRESEN	NTATIVE'S SI	GNATURE/NAME)			
ADDRESS		(1	ADDRESS	) ATTO	RNEY; NON ATT	DRNEY		
CITY	STATE	ZIP CODE C	ITY		STATE	Z	IP CODE	
DATE	AREA CODE AND TELEPHO	NE NUMBER D	ATE		AREA COD	E AND TELEPHONE	NUMBER	
TO BE COMPLE	TED BY SOCIAL SECURITY	ADMINISTR	ATION-	ACKNOWI	EDGMENT OF RE	QUEST FOR H	EARING	
10.	RECEIVED for the Social Security A				by:			
(TITLE)  11. Is the request fo	r hearing received within 65 days	DDRESS of the If	no is che	cked. attach	Servic claimant's explanation	3	Code ach copy of	
reconsidered det		ар	pointmen		er, or other pertinent	-		
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	aw Judge of the Office of Heal ce of the time and place of a h					er proceedings in you	ur case.		
	onal evidence to submit check te the statement:	the following			e of the blocks: h to appear at a hearing				
	I have additional evidence to submit from (Name and address of source):				do not wish to appear and I request that a decision be made based on the evidence in my case.  (Complete Waiver Form HA-4608)				
	o the Social Security Office wirelands all sheet if you need more space								
	be represented at the hearing. service organizations. (If you ar				to be, your Social Secur	ty Office will give yo	ou a∃ist		
	te No. 8 and your representa this form, you should also pri				ou are represented and	your representative	; is not		
(CLAIMANT'S SIGNA	ATURE)		(REPRESENTATIVE'S SIGNATURE/NAME)						
ADDRESS			(ADDRESS) ATTORNEY; NON ATTORNEY						
CITY	STATE	ZIP CODE	CITY		STATE	ZIP C	ODE		
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TO BE COMPLE	TED BY SOCIAL SECUR	ITY ADMINIS	 Γ <mark>RATION</mark> -	ACKNOWI	EDGMENT OF REC	UEST FOR HEA	RING		
10. Request for Hearing	RECEIVED for the Social Secur	ity Administration	on		by:				
(TITLE)		ADDRESS			Servicino	FO Code PC Co			
	or hearing received within 65 d		If no is che	cked, attach	claimant's explanation f				
reconsidered de YES NO	termination?			nt notice, lett urity Office	er, or other pertinent m	aterial or information	n in the		
12. Claimant not represented -  list of legal referral and service organizations provided				13. Interpreter needed - enter language (including sign language):					
14. Check one: Initia	I Fuelithanian Cons		15.	4 (-).					
Disa	l Entitlement Case bility Cessation Case		Check clai	,,		ĺ	(RSI)		
Other Postentitlement Case				•	child only		(DIWC)		
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			III Other	Specify (			1		

#### PRIVACY ACT AND PAPERWORK ACT NOTICE

The Social Security Act (sections 205(a), 702, 1631(e)(1)(A) and (B), and 1869(b)(1) and (c), as appropriate) authorizes the collection of information on this form. We need the information to continue processing your claim. You do not have to give it, but if you do not you may not receive benefits under the Social Security Act. We may give out information on this form without your written consent if we need to get more information to decide if you are eligible for benefits or if a Federal law requires us to do so. Specifically, we may provide information to another Federal, State, or local government agency which is deciding your eligibility for a government benefit or program; to the President or a Congressman inquiring on your behalf; to an independent party who needs statistical information for a research paper or audit report on a Social Security program; or to the Department of Justice to represent the Federal Government in a court suit related to a program administered by the Social Security Administration. We explain, in the Federal Register, these and other reasons why we may use or give out information about you. If you would like more information, get in touch with any Social Security Office.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information about you may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 35 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number.

#### TIME IT TAKES TO COMPLETE THIS FORM

We estimate that it will take you about 10 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. If you have comments or suggestions on this estimate, write to the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235-0001. Send only comments relating to our "time it takes" estimate to the office listed above. All requests for Social Security cards and other claims-related information should be sent to your local Social Security office, whose address is listed under Social Security Administration in the U.S. Government section of your telephone directory.